



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
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CHERYL BARTLETT, RN
COMMISSIONER

DATE: July 19, 2013

TO: Physicians, Nurse Practitioners, Certified Athletic Trainers, and Neuropsychologists Providing Medical Clearance for Return to Play for Students With Sports-related Head Injuries

FROM: Cheryl Bartlett, RN
MDPH Commissioner

A handwritten signature in blue ink, appearing to be "CB", written over the printed name and title of Cheryl Bartlett.

RE: Training Requirement of Sports Concussion Regulations for Clinicians Providing Medical Clearance

In order to promote the safety and wellbeing of young athletes in Massachusetts, in 2010 a state concussion awareness law passed (Chapter 166 of the Acts of 2010) that called for educating athletes and their parents about concussions, documenting the student athletes' past head injuries, requiring removing injured students from practice or play, and providing medical clearance for "return to play". Subsequently, the Massachusetts Department of Public Health (MDPH) promulgated regulations for schools regarding sports-related head injuries (105 CMR 201: Head Injuries and Concussions in Extracurricular Activities). In response to these regulations, schools must develop policies that address medical clearance and return to play for students with sports-related head injuries.

As part of these regulations, there is a requirement that by September 2013, physicians, nurse practitioners, certified athletic trainers, and neuropsychologists providing medical clearance for return to play *shall verify that they have received Department-approved training in traumatic head injury assessment and management* or have received equivalent training as part of their licensure or continuing education. MDPH has developed a Medical Clearance Form (attached) to include an affirmation that the clinician providing clearance has taken this approved MDPH Clinical Training.

Options for MDPH-approved clinical training as well as the Medical Clearance Form can be found at: www.mass.gov/dph/sportsconcussion (under heading "MDPH Approved Clinical Training"). Participation in one of these options will ensure your ability to provide medical clearance under these regulations.

On behalf of the Department of Public Health, I would like to thank you for your help in implementing this important legislation and look forward to working with you as we continue to protect our student athletes.



**The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
POST SPORTS-RELATED HEAD INJURY
MEDICAL CLEARANCE AND AUTHORIZATION FORM**

This medical clearance should be only be provided *after* a graduated return to play plan has been completed and student has been symptom free at all stages. ***The student must be completely symptom free at rest and during exertion prior to returning to full participation in extracurricular athletic activities.***

Student's Name	Sex	Date of Birth	Grade
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Date of injury: _____ Nature and extent of injury: _____

Symptoms (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Headaches | <input type="checkbox"/> Light/noise sensitivity |
| <input type="checkbox"/> Dizziness/balance problems | <input type="checkbox"/> Double/blurred vision | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Feeling sluggish/"in a fog" | <input type="checkbox"/> Change in sleep patterns | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Irritability/emotional ups and downs | <input type="checkbox"/> Sad or withdrawn |
| <input type="checkbox"/> Other | | |
| <input type="checkbox"/> | | |

Duration of Symptom(s): _____ Diagnosis: ☐ Concussion ☐ Other: _____

If concussion diagnosed, date student completed graduated return to play plan without recurrent symptoms: _____

Prior concussions (number, approximate dates): _____

Name of Physician or Practitioner: _____

☐ Physician ☐ Certified Athletic Trainer ☐ Nurse Practitioner ☐ Neuropsychologist

Address: _____ Phone number: _____

Physician providing consultation/coordination (if not person completing this form): _____

I HEREBY AUTHORIZE THE ABOVE NAMED STUDENT FOR RETURN TO EXTRACURRICULAR ATHLETIC ACTIVITY AND ATTEST THAT I HAVE RECEIVED CLINICAL TRAINING IN POST-TRAUMATIC HEAD INJURY ASSESSMENT AND MANAGEMENT APPROVED BY THE DEPARTMENT OF PUBLIC HEALTH* OR HAVE RECEIVED EQUIVALENT TRAINING AS PART OF MY LICENSURE OR CONTINUING EDUCATION.

Physician or Practitioner signature: _____ Date: _____

Please indicate type of clinical training received (optional):

☐ DPH Clinical Training ☐ On-line Training ☐ Other (Describe) _____

*By September 2013, physicians, nurse practitioners, certified athletic trainers, and neuropsychologists providing medical clearance for return to play shall verify that they have received Department-approved training in post traumatic head injury assessment and management or have received equivalent training as part of their licensure or continuing education. This MDPH approved Clinical Training can be found at:

www.mass.gov/dph/sportsconcussion